**SUBMITTED QUESTIONS/COMMENTS FROM OUTPATIENT HOSPITAL FEE SCHEDULE – HOSPITAL BILLING TRAINING**
**6/28/2005**
**Responses as of: 7/7/2005**

Will you please publish all relevant/pertinent questions & answers for this training session on the AHCCCS Website? And notify all who attended (not just CEO's) when posted? **- Agreed**

Verify whether or not Revenue Code 681 should be included in the Bundled Revenue code list for Surgery and E/R. – **Yes, corrected 6/30**

Should revenue code 278 be included in the listing of valid revenue codes for O/P? If not, why? - **Yes, corrected 6/30**

Should revenue code 272 require a HCPCS/CPT? **Yes, corrected to Optional 6/30**

Please also look at revenue code 276. – Response in progress 7/6.

Are surgeries bundled with all charges? – **Please clarify this question to the Outpatient Workgroup email address. Bundled revenue codes and exception procedures for Surgical Bundling are documented and were shared with the group.**

Please provide a list of Surgeries which are not subject to multiple surgery logic. – **This information will be posted to the Website as an extract from table RF789.**

How often is the Fee Schedule updated? – **Generally annually.**

When will the default Cost to Charge be updated? – **Updates should be infrequent and normally tied only to rebasing of rates.**

As stated per line – only allowed # of units will be paid. How do we know how many units will be allowed per Rev Code. - Response in progress 7/6.

Why is 99217 not appropriate for hospital billing? (Observation Services) – **The internal AHCCCS Work group did not feel that 99217 was appropriate as this code is observation care discharge day management, used by physician to report if discharge is not on initial date of observation status, whereas codes we are using are not discharge codes but are codes for observation care and can be billed hourly by hospital.**

Please verify that "J" code rates are appropriate, they appear to be much lower than Medicare. - **J codes rates are based on the physician fee schedule rates, and pretty much matched Medicare when they were updated in the Spring. AHCCCS is aware that there are some updates Medicare has posted for July and is in the process of reviewing these. If there are particular examples of concern please let us know via the Outpatient Workgroup email address.**

How do we find if we need a peer group modifier? Please don't forget to list modifiers on your website. – **Peer Group modifiers are a term used to describe the % of the Fee Schedule that AHCCCS will reimburse groupings of Hospitals. This % is automatically applied and has no reporting requirements.**

Revenue code 636 not listed on extract of valid revenue code and bill type for O/P Hospital billing. - **Revenue code 636 should be valid for OP bill types; AHCCCS is aware that hospitals are using that revenue code for chemo drugs. We will verify and correct the table as necessary.**

Noticed 386 revenue code – for CPT/HCPC P9045. I was informed that AZ is a blood free state (Blood is donated) and that rev 386 is not valid revenue. We use Rev 390 and 391. Please advise if this is correct. - Response in progress 7/6.

Will claims be editing for HCPCS/CPT, which CMS are requiring (device code attached)? – **Please clarify this question via the Outpatient Workgroup email address and we will get you a response as quickly as possible.**

Will you be following the OCE updates? – **AHCCCS will follow OCE edits, but may not implement all or at the same time, as Medicaid coverage differs from Medicare in some areas.**

Are you following CMS Payment Status Indicators such as S&T, N, K, etc.? – **AHCCCS has not implemented status indicators at this time. If and when these are implemented, AHCCCS will not be implementing all values. However, AHCCCS is following the logic for status indicators S&T through our internal tables.**

Should we use bill type 137 for the adjustment of previously paid claims? – **Yes.**

How are these changes going to effect getting authorizations? – **Will not impact AHCCCS FFS authorizations. Please contact individual health plans for specific requirements.**

Can we bill with the new 7/1/05 requirements even if the Health Plan is not ready to pay as the new methodology? – **Yes.**

We are a CAH, AHCCCS is secondary to Medicare. What claim form do you want submitted? – **All hospital claims must be submitted on either a hardcopy UB92 claim form or via the 837I electronic file format.**

Multiple Questions related to similar data content issues –

If Hospital E/R admit date and discharge date does not match (service spans midnight), will claim reject, pend or deny? – **Should not be an issue, no change to the allowance of date spans for O/P.**

For "service begin date and state date of care date should be the same date", which specific form locators on the UB92 does this refer to? And, is this requirement specific to O/P claims. For example, does this requirement apply to an E/R visit upgraded to full admit after midnight? – **Fields 6A-B and 17. Specific to O/P claims only. Does not apply to any I/P admissions regardless of the source.**

Service date: Can the service date span 2 days? For example, the patient come to the ED on July 1 at 11:00pm and is discharged on July 2 at 10:00am. - **Should not be an issue, no change to the allowance of date spans for O/P.**

Please clarify the correct billing for outpatient services for Box 6, 7 and 17. How do we prevent denials stating dates and dollar amounts don't match? Example – pre-op labs done on 6/5 and surgery done on 6/8, how should this be billed? There is only one authorization for surgery. – **AHCCCS does not current edit for the condition described. Consult the individual health plans for authorization requirements.**

ER patient comes in on 6/4 at 11:35 pm – care goes over to 6/5 – lab ER room level has date 6/4 – radiology and pharmacy has 6/5 date how do we bill? – **Field 6A-B = 6/4 and 6/5; dates of service as applicable at the line level for services.**

Clarify admission dates from ER to inpatient. – **No change to current I/P requirements.**

If patient is ER prior to midnight and admitted after midnight. Are we correct to use dates of service from-to (6A/B) to include the ER date? But the admission date (17) as the next day when patient was true admit? - **No change to current I/P requirements.**

Need clarification on FL 6A-B and FL17. Patient in ED 7/1 and admitted as inpatient on 7/2, discharged on 7/3. Our system shows service date of: 72-7/3 with ED charges on claim for 7/1, FL6 = 7/2 -7/3, FL17 – 7/2. - **No change to current I/P requirements.**

For O/P – observation admit – FL6-A-B, will show 7/1 – 7/3 with FL17 showing 7/2 as the "admit date" to observation status. Medicare (BCBSAZ FI) has clarified to us not to show the admit date in FL17 the same as the beginning of svc in FL6A when there is an admit after midnight (I/P). Otherwise in the Medicare world, we would be using up an Inpatient day inappropriately. I have a letter from Lisa Lisenberg I could share. - Response in progress 7/6. - **For AHCCCS purposes, if there is not an accommodation revenue code billed, and bill type is outpatient, we consider bill as outpatient. However, there is a 23 hour limit to observation unless hospital receives authorization to extend the time. AHCCCS coverage of observation is not the same as Medicare's, for instance, Medicare does not cover observation for labor.**

Start of Care (O/P) – turns into Admission Date. Please confirm whether split billing is 'required' and if so what services should be split? Which are I/P vs. O/P? - **No change to current I/P requirements.**